



## As uses widen for intrauterine contraception, why haven't ObGyns become advocates?

↪ Unintended pregnancies would likely decline if we prescribed these methods of birth control more often

**T**wo critical goals of contraceptive care are to **maximize the number of planned pregnancies** and **minimize the number of unplanned pregnancies**. Reversible, long-acting contraceptives—including the hormonal implant (Implanon), depot medroxyprogesterone injection (Depo-Provera), and intrauterine contraception (Mirena, Paragard)—play a key role in reaching those goals. And for the near future, there's promise of long-acting male hormonal contraception.

But are we, as a specialty, doing all we can when counseling patients about contraception and prescribing the options available to them? Scant use of intrauterine contraceptives (IUCs) in the United States, for one, suggests that the answer is “No” and that we can do much to improve our role as leaders in women's health.

### A shift in the landscape of contraceptive care

The frequency of IUC use differs greatly from one country to another. In the period from, roughly, 1998 to 2004, the percentage of women using

contraception who used an intrauterine method was, for example, 33% in Turkey and 50% in China—but only 2% in the United States.<sup>1</sup> This variance is probably due, in part, to patient preference—but physicians also play a key role in advocating this method.

IUCs are highly effective, easily removed, and very safe. The fact that they are utilized at such a comparatively low rate in the United States **1)** suggests that physicians here are not encouraging their use and **2)** summons the ObGyn community to take the lead and prescribe them more often when they are indicated.

Taking such a leadership role is all the more significant because practice patterns in regard to contraception are changing rapidly. New approaches to the use of intrauterine contraception, for example, include:

- placing the device immediately after abortion
- placing it immediately after delivery of the placenta at birth
- using intrauterine contraception in nulliparous women and in adolescents.<sup>2</sup>

What follows here is essential information and encouragement on those emerging indications.

#### After abortion

Women are highly motivated after an abortion to initiate effective con-

traception. In a systematic review of available data, investigators concluded that an IUC can be placed safely, and easily, immediately after therapeutic abortion.<sup>3</sup>

In another study, in which 440 women had an IUC placed immediately after abortion, the expulsion rate was 7% for the Nova T device and 8% for the levonorgestrel-releasing intrauterine system (LNG-IUS [Mirena]). In contrast, the expulsion rate was 3% for interval insertion of those two devices.<sup>4</sup>

By performing a so-called Monte Carlo simulation analysis, researchers found that placing an IUC immediately after abortion is associated with fewer pregnancies than just recommending a plan to place one at a follow-up visit.<sup>5</sup>

#### After delivery of the placenta at birth

The idea of placing an IUC immediately after the placenta is delivered at birth isn't new. In 1980, for example, investigators reported a trial of high-fundal placement of IUDs in more than 1,000 women after they delivered the placenta.<sup>6</sup> The continuation rate at 12-month follow-up was 62%.

In most series, the intrauterine device is placed within 10 minutes of delivery of the placenta. Typically, it is placed high in the uterine fundus, using ring forceps or by hand.

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Do you know which of your patients are not candidates for intrauterine contraception?

**Instant Poll**

↗ on page 10

## Instant Poll

### THIS MONTH'S POLL IS A QUIZ

In which of the following populations or conditions is intrauterine contraception contraindicated?

- HIV-positive women
- Acute pelvic infection
- Adolescence
- Severe distortion of the uterine cavity
- Nulliparity
- Prior ectopic pregnancy
- Breast-feeding
- Valvular heart disease

See the correct answer on page 14 of this issue

The principal disadvantage of inserting an IUC immediately after delivery of the placenta is an observed increase in the rate of expulsion, compared with what is seen with interval insertion. In a review of available studies, the expulsion rate after delivery was 10% to 15%.<sup>7</sup>

#### In a nulliparous woman

The FDA approved the use of the copper T 380A intrauterine device (ParaGard) for nulliparous women because the agency recognized the value of intrauterine contraception—that is, an easily reversible, long-acting, highly effective method with a low rate of associated adverse events.

Placing an IUC in a nulliparous woman is facilitated by pretreating her with misoprostol approximately 1 hour beforehand.<sup>8</sup>

#### In an adolescent

Although research data on intrauterine contraception in this population are scant, an ACOG expert panel concluded that both nulliparous and parous adolescents are candidates for intrauterine contraception.<sup>9</sup>

The reported continuation rate among adolescents who use an IUC varies—from approximately 75% at 1 year to 30% to 40% at 3 to 4 years. Although the expulsion rate for IUCs may be higher in adolescents than it is in adults, continuation and effectiveness are as good as, or better than, that seen with other contraceptive methods available to adolescents.<sup>10</sup>

*Note:* The high prevalence of *Chlamydia trachomatis* infection in adolescents may warrant screening for chlamydial infection in these patients before placement of intrauterine contraception.

The same is true for gonococcal infection.

#### The LNG-IUS in a woman taking tamoxifen

Tamoxifen is often prescribed for women who have estrogen-receptor-positive breast cancer. In the uterus and endometrium, tamoxifen acts as a partial estrogen agonist and is associated with an increased risk of endometrial polyps and endometrial cancer.

Placement of an LNG-IUS in a woman who is taking tamoxifen for breast cancer appears to reduce her risk of developing endometrial polyps. In a recently published trial, 113 women who had breast cancer and were taking tamoxifen were randomized to either **1**) placement of an LNG-IUS plus endometrial surveillance (by transvaginal ultrasonography) or **2**) endometrial surveillance only.<sup>11</sup>

After, on average, approximately 25 months of follow-up, new polyps arose in eight women who had not been assigned to have an LNG-IUS placed. New polyps arose in three women randomized to receive an LNG-IUS but, notably, none of those three had the LNG-IUS in place at the time the polyp was diagnosed: two, because they had had the device removed; one, because the device had, in fact, never been placed.

#### Emphasis on intrauterine contraception promises benefit for women

Every contraceptive option has its strengths and relative weaknesses. Barrier contraceptives, such as male and female condoms, for example, may reduce the risk of sexually transmitted disease but are sometimes used irregularly in real life—resulting in a high rate of unintended pregnancy.

Intrauterine contraception, on the other hand, very seldom results in unintended pregnancy. By in-

creasing the use of IUC—to levels achieved in China, Turkey, and Western Europe—ObGyns in the United States would play a leadership role in what would likely be a reduction in unintended pregnancies. Such a shift would be an important development in women's health. 📧



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